MCH2010

Enhancing the health of Kansas women and children through partnerships with families and communities.

Kansas Maternal and Child Health 5-Year Needs Assessment

Bureau for Children, Youth, and Families
Kansas Department of Health and Environment

2005

K A N S A S

RODERICK L. BREMBY, SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

DEPARTMENT OF HEALTH AND ENVIRONMENT

May 9, 2005

Dear Fellow Kansans:

It is my very great pleasure to provide a foreword to the five-year Maternal and Child Health Needs Assessment for the State of Kansas.

We all know that children are resilient and adaptable. But we also know that they are vulnerable to changing health, environmental, and societal conditions. A better understanding of the trends in the health of children and the circumstances that influence those trends can enhance our understanding of how Kansans should proceed in addressing vulnerabilities and enhancing resiliencies.

At the same time, when there is increased emphasis on performance accountability, downsizing, scarce resources at the local, state, and federal levels, it is imperative that our public policy and program decision-making be as well-informed as possible. When there are competing, powerful interest groups vying for scarce resources, it imperative that we bring together all the key stakeholders with an interest in the health of children, to review the data showing trends and predictive of future direction.

Informed decision-making and involvement of key stakeholders in decision-making are the foundation upon which this document is based. Key stakeholders were involved in meetings during which they examined the data and shared their own understanding of key issues. ***Nine state priorities for the years 2006-2010 were selected.***

I hope that you will join with me in supporting the selected priorities through your own efforts and those of our Department.

Sincerely,

Howard Rodenberg, MD, MPH
Director of Health

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Table of Contents

Appendices

MCH2010

Enhancing the health of Kansas women and children through partnerships with families and communities.

Kansas Maternal and Child Health 5-Year Needs Assessment

Executive Summary

As a recipient of federal Title V - Maternal and Child Health Services Block Grant funds, Kansas is required to complete a statewide maternal and child health needs assessment every five years. Kansas' five year needs assessment, referred to as MCH2010 because it covers the period of federal fiscal years 2006 to 2010, has resulted in an identification of priority needs for the maternal and child health population.

The Bureau for Children, Youth and Families (BCYF) within the Kansas Department of Health and Environment (KDHE) coordinates the needs assessment and administers Title V funds. The mission of the Bureau for Children, Youth, and Families, which was a theme of the MCH2010 needs assessment, is to "provide leadership to enhance the health of Kansas women and children through partnerships with families and communities."

During the summer and fall of 2004, 77 Expert Panelists participated in MCH2010 and identified priority needs for each of the three maternal and child health (MCH) population groups: Pregnant Women and Infants, Children and Adolescents, and Children with Special Health Care Needs. The priority needs identified by the Expert Panelists are as follows:

Pregnant Women and Infants

- Increase early and comprehensive health care before, during, and after pregnancy.
- Reduce premature births and low birthweight.
- Increase breastfeeding.

Children and Adolescents

- Improve behavioral/mental health.
- Reduce overweight.
- Reduce injury and death.

Children with Special Health Care Needs

- Increase care within a medical home.
- Improve transitional service systems for CSHCN.
- Decrease financial impact on CSHCN and their families.

Three additional focus issues were also chosen: (1) reduce teen pregnancy and sexually transmitted diseases, (2) improve oral health, and (3) improve asthma diagnosis and treatment.

The Panel of Experts drafted specific strategies for addressing each priority need and focus issue. Expert Panelists also assessed the capacity of the state MCH system and recommended first steps for KDHE staff to provide leadership in systems development.

The draft document was posted on the KDHE website for a 90 day public comment period which ended May 6, 2005. The final needs assessment report is submitted with the MCH Title V Block Grant Application on July 15, 2005. The beginning of the federal fiscal year on October 1, 2005 marks the official implementation of actions and strategies to address priority needs.

MCH2010 represents only the first steps in a cycle for continuous improvement of maternal and child health. Between 2005 and 2010, actions and strategies will be implemented, results will be monitored and evaluated, and adjustments will be made as necessary to continue to enhance the health of Kansas women, infants, and children.

Acknowledgements

Many individuals were integral to the MCH2010 process.

The **MCH2010 Expert Panelists** are listed below. These individuals represent a broad range of expertise in maternal and child health issues. They were the central decision-makers for the assessment process.

Susan Arnold, Families Together

Mary Baskett, Kansas Head Start Association

Mary Ann Bechtold, Special Health Services-Topeka

Kristin Blevins, Consumer Representative

Dena Bracciano, Douglas County Infant Toddler

Ginger Breedlove, Kansas University School of Nursing

Melissa Brooks, Coordinated School Health Program

Jane Byrnes-Bennett, Midwest Dairy Council

Ted Carter, BCYF, KDHE

Judy Clouse, BCYF, KDHE

Lynne Crabtree, American Lung Association

Cindy D'Ercole, Kansas Action for Children

Juanita Dewey, Thomas County Health Department

Patricia Dunavan, KDHE

Kathryn Ellerbeck, Developemental Disabilities Center

John Evans, Stormont-Vail Regional Medical Center

Eileen Filbert, Jefferson County Health Department

Allison Koonce, Coordinated School

Jimmie Gleason, Kansas Medical Insurance Co.

Lizbeth Gogolski, Stormont-Vail Regional Medical Center

Greta Hamm, KS Dept. of Social and Rehabilitation Services

Norm Hess, March of Dimes

Janelle Hill, Consumer Representative

Pat Hirsch, Mitchell County Health Department

Abby Horak, Public Management Center

Rosie Howlett, Wyandotte County Health Department

Kathy Johnson, T.A.R.C.

Jacqueline Jones, FirstGuard

Jean Jorgensen, University of Kansas - Beach Center

Nancy Jorn, Lawrence-Douglas County Health Department

Pam Keller, KS Dept. of Social and Rehabilitation Services

Jamey Kendall, KDHE

Jane Kennedy, Special Health Services-Topeka

Linda Kenney, KDHE

Jamie Kim, BCYF, KDHE

Jamie Klenklen, BCYF, KDHE

Guadalupe Klos, Crawford County Health Department

Health Program

Joseph Kotsch, KDHE

Darrel Lang, Kansas State Department of Education

Martin Maldonado-Duran MD, Family Service & Guidance

Monica Mayer, KS Dept. of Social and Rehabilitation Services

Marcia McComas, Special Health Services-Wichita

Julie McCoy, Special Health Services-Wichita

Dawn McGlasson, KDHE

Ileen Meyer, KDHE

Vicki Miller, Developmental Disabilities Center

Carol Moyer, BCYF, KDHE

Carolyn Nelson, Infant Toddler Services

William Pankey, First Guard Health Plan

Gianfranco Pezzino, Kansas Health Institute

Amanda Pierpont, Consumer Representative

Jennifer Prince, Consumer Representative

Wm. Randy Reed, Dept of Neonatology Wesley Med. Ctr.

Matt Reese, Developmental Disabilities Center

Pat Rion, Crawford County Health Department

Candice Rukes, Consumer Representative

Debra Rukes, YWCA Teen Pregnancy Prevention Program

Elaine Rupp, Hays Area Children's Center

Kathy Ryan, Thomas County Health Department

Kristi Schmitt, Finney County Health Department

Georgetta Schoenfeld, Logan County Health Department

Judith Seltzer, Reno County Health Department

Mary Ann Shorman, Kansas School Nurse Organization

David Sierra, Consumer Representative

Maria Sierra, Consumer Representative

Jan Stegelman, Kansas Safe Kids

Jane Stueve, KDHE

Theresa Tetuan, KDHE

Cyndi Treaster, KDHE

Christine Tuck, KDHE

Dale Walters, Catholic Community Services

Mary Washburn, KDHE

Polly Witt, Garden City Public Schools

Debbie Wolfe, Sterling Medical Center

Each MCH2010 Expert Panelist was assigned to one of three workgroups: Pregnant Women and Infants, Children and Adolescents, and Children with Special Health Care Needs. Assisting each work group was a team of three individuals: a facilitator, a data expert, and a recorder. The individuals who provided this assistance to the workgroups are listed below.

Workgroup	Pregnant Women and Infants	Children and Adolescents	Children with Special Health Care Needs
Facilitator	Jean DeDonder, Emporia State University	Ted Carter, BCYF, KDHE	Donita Whitney-Bammerlin, Kansas State University
Data Expert(s)	Carol Moyer, BCYF, KDHE	Carol Moyer, BCYF, KDHE Connie Satzler, EnVisage	Jamie Kim, BCYF, KDHE
Recorder	Judy Clouse, BCYF, KDHE	Jamie Klenklen, BCYF, KDHE	Julie McCoy, Special Health Services - Wichita

Connie Satzler of EnVisage Consulting in Manhattan, Kansas served as **Project Manager** for MCH 2010 with the assistance of her staff, Rebekah Brown, Wendy Popp, and David Ray.

Marjory Ruderman from Johns Hopkins University Women's and Children's Health Policy Center served as **Facilitator for MCH Capacity Assessment** at the third meeting of Expert Panelists.

The following individuals planned the assessment process and provided **Project Oversight:** Linda Kenney, Director, Bureau for Children, Youth and Families; Jamey Kendall, Director, Children with Special Health Care Needs Section; Ileen Meyer, Director, Children & Families Section.

Introduction

Each year, the Kansas Department of Health and Environment (KDHE) receives approximately $4.9 million through the Maternal and Child Health Services Title V Block Grant from the Maternal and Child Health Bureau of the Health Resources and Services Administration.

Maternal and Child Health Population Groups:

- *Pregnant Women and Infants*
- *Children and Adolescents*
- *Children with Special Health Care Needs*

As a recipient of Title V funds, Kansas is required to complete a statewide needs assessment every five years to identify the need for

- preventive and primary care services for pregnant women and infants,
- preventive and primary care services for children, and
- services for children with special health care needs (CSHCN)

Kansas' five-year needs assessment, referred to as MCH2010 because it covers the period of federal fiscal years 2006 to 2010, has resulted in an identification of the priority needs of the maternal and child health (MCH) population over the next five years. Specifically, three priorities were identified for each of the three MCH population groups (Pregnant Women and Infants, Children and Adolescents, and Children with Special Health Care Needs).

"Provide leadership to enhance the health of Kansas women and children through partnerships with families and communities."

- Mission of Kansas maternal and child health program

The Bureau for Children, Youth and Families (BCYF) within KDHE coordinated the needs assessment, administers Title V funds, and will provide leadership for addressing priority needs over the next five years. The mission of the Bureau for Children Youth, and Families, which became a theme of the needs assessment, is to "provide leadership to enhance the health of Kansas women and children through partnerships with families and communities."

Background

Title V

The Title V MCH Block Grant program serves over 27 million women, children, youth and families in all 50 states, the District of Columbia and eight U.S. territories. Authorized under Title V of the Social Security Act, the MCH Block Grant is the only federal program devoted to improving the health of all women, children, youth and families.

To learn more about the Title V program, refer to the Title V Information System (TVIS) website at https://performance.hrsa.gov/mchb/mchreports. This website includes financial and program information, indicator data, grant applications, and the most recently submitted five-year needs assessments for Kansas and all other Title V grant recipients.

Kansas MCH Needs Assessments

The first comprehensive maternal and child health five-year needs assessment was completed in 1995 and covered the period of 1996 to 2000. The second comprehensive needs assessment was completed in 2000 for 2001 through 2005. These needs assessments drew heavily from quantitative data such as demographic data, health status data, and other health-related data. In 2003, a mid-course review of the 2001-2005 needs assessment was completed, which drew heavily from qualitative studies, including interviews with local health departments and focus groups with consumers.

Needs Assessment Process

Overview

The MCH2010 process built on lessons learned in the previous two needs assessments. Quantitative and qualitative data were still used, but the process was organized around stakeholder involvement. Three one-day meetings with stakeholders were scheduled.

Meeting 1:

- *What is the plan?*
- *What else do we need to know?*

Meeting 2

- *Based on available data, what are the priorities?*
- *What are strategies for addressing the priorities?*

Meeting 3

- *What is the capacity of the MCH system to meet the priority needs?*

Date	What Was Accomplished
June 25, 2004	Overview of needs assessment process Identification of additional data needed
August 16, 2004	Review of data indicators Selection of priority needs Preliminary identification of strategies to address priorities
October 29, 2004	Identification of strengths, weaknesses, opportunities, and threats Evaluation of Kansas MCH capacity

Organizational Structure

MCH2010 Planning Team

An MCH2010 Planning Team was identified, which consisted of the following members: BCYF Director, Children & Families Section Director (representing both the pregnant women & infants and children & adolescents population groups), Children with Special Health Care Needs Section Director, both BCYF MCH epidemiologists, a contracted project manager, and the three facilitators (one internal to BCYF and two contracted facilitators).

For Meeting #3, Marjory Ruderman from Johns Hopkins University Women's and Children's Health Policy Center, provided leadership in MCH Capacity Assessment. Ms. Ruderman was a developer of CAST-5 (Capacity Assessment for State Title V), which is a set of tools for MCH Title V programs to use in assessing capacity.

Stakeholders: MCH2010 Panel of Experts

"I found the networking to be professionally and personally interesting. I see that Kansans may not network enough – between professionals and professions, geographic areas, between government entities. I did like the cross-fertilization of ideas and discussions from so many perspectives."

- Stakeholder comment

MCH program staff at KDHE identified stakeholders representing each of the three population groups (pregnant women and infants, children and adolescents, and children with special health care needs). The stakeholders broadly represented MCH concerns in Kansas and included family representatives, adolescents, health care providers, and program staff as well as representatives from other state agencies, local health departments, universities, not-for-profit organizations, and advocacy groups. These 77 representatives became the MCH2010 Panel of Experts. See Acknowledgements Section for a complete listing of panel members.

MCH2010 Population Workgroups

For each of the meetings, the Expert Panel divided their time between plenary sessions and workgroup sessions. Each participant was assigned to one of three workgroups:

- Pregnant Women and Infants
- Children and Adolescents
- Children with Special Health Care Needs

Each workgroup had three "staff" for the entire process:

- Facilitator
- MCH Epidemiologist or data expert
- Recorder

The workgroups used "tools", or worksheets to structure discussion, to help keep on task and to record decisions and progress for BCYF staff. Although all workgroups used the same tools, facilitators had the flexibility to modify a tool or process if they discovered something was not working well for their groups.

Timeline

Key events related to the needs assessment process are listed in the following table. Activities centered on the three stakeholder meetings, with the Planning Team preparing for the next meeting, evaluating the progress, and providing staff support to the assessment in-between meetings.

Date	**Event**
Fall, 2003	BCYF start-up planning
Spring, 2004	Project manager and facilitators on-board, potential stakeholders identified
April 27, 2004	Initial planning meeting with project manager and MCH staff
May 4, 2004	Invitation letters sent to Stakeholders
May 24, 2004	MCH2010 Planning Team met to plan Meeting #1
May-June, 2004	MCH Epidemiologists compiled and summarized MCH-related indicators and prepared detailed overview of additional indicators available
June, 2004	MCH Capacity Assessment expert on-board
June 2, 2004	Facilitator training
June 15, 2004	Meeting #1 packets sent to Stakeholders (MCH2010 Panel of Experts)
June 25, 2004	**Meeting #1 with MCH2010 Panel of Experts**
June 28, 2004	Debriefing on Meeting #1 with MCH2010 Planning Team
July 2, 2004	Meeting #1 results sent to Panel of Experts for review
July 13, 2004	Facilitator preparation for Meeting #2
July 15, 2004	Meeting #1 evaluation surveys emailed to Panel of Experts
July 19, 2004	Conference call with MCH Capacity Assessment expert
July 29, 2004	Meeting #1 evaluation results reported to Planning Team
July- August, 2004	MCH Epidemiologists analyzed and compiled additional data requested by Panel of Experts in Meeting #1, prepared data for presentation at Meeting #2
August 2, 2004	Meeting #2 packets sent to Panel of Experts
August 16, 2004	**Meeting #2 with MCH2010 Panel of Experts**
August 21, 2004	Meeting #2 evaluation results reported to Planning Team
September 16, 2004	Debriefing on Meeting #2 with Planning Team
September 24, 2004	Meeting #2 results emailed to Panel of Experts for review and comment
September 30, 2004	Facilitator training for Meeting #3 with MCH Capacity Assessment expert

Date	**Event**
September-October, 2004	Comments received from Panel of Experts and reviewed by Planning Team, BCYF staff refined list of priority needs and strategies
October 15, 2004	Meeting #3 packets sent to Panel of Experts
October 29, 2004	**Meeting #3 with MCH2010 Panel of Experts**
November 5, 2004	Meeting #3 evaluation results reported to Planning Team
November 22, 2004	Debriefing on Meeting #3 with Planning Team
December 14, 2004	Meeting #3 results emailed to Panel of Experts for review.
December 22, 2004	Final report of capacity assessment results received from MCH Capacity Assessment expert and reviewed by core Planning Team
December, 2004 - January, 2005	Final Needs Assessment Report prepared by MCH Planning Team
February, 2005	Draft Needs Assessment Report posted online for review

Meeting #1

In this section, a summary of the agenda, tools used, and progress made from Meeting #1 are presented.

Agenda

- Plenary Sessions
  - Detailed Overview of Title V and Tile V Needs Assessment
  - Data-Driven Decision Making
- MCH Population Workgroup Sessions
  - Review of Data Indicators
  - Final Selection of Key Indicators
  - Determination of Data Needed for Decision Making

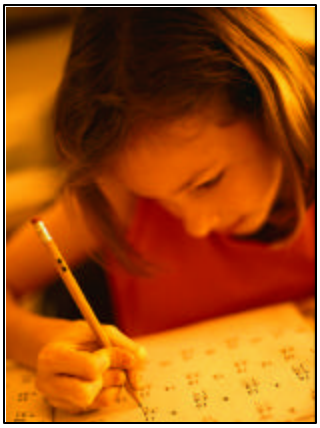
"Hearing the many and diverse issues makes me understand the extreme difficulty in prioritizing needs. It is good to see outcomes will be identified based on an analysis of available data."

- *Stakeholder comment after Meeting #1*

Tools

The Tools used in Meeting #1 are listed below, and copies are included in Appendix A.

Tool	**Task Description**
Pre-Meeting Assignment for Panel of Experts members	Review indicator list for MCH population group and determine five *most* important and five *least* important indicators based on criteria listed.
Tool #1: Data Indicator Selection	Review indicator listing and determine data indicator needs for priority selection.
Tool #2: Additional Data Needed	List additional data needs and desired stratifications.



Data

Lists of indicators by MCH population group were provided to the Panel of Experts before and at Meeting #1. Stakeholders reviewed these lists using the Pre-Meeting Assignment and Tool #1. Nationally- or state-recognized indicators with standardized definitions were chosen from the following sources:

- Centers for Health and Environmental Statistics, KDHE
- Healthy People 2010
- Health Status Indicators from MCH Block Grant
- Health Systems Capacity Indicators from MCH Block Grant
- Previous MCH Needs Assessment
- Kansas Information for Communities, KDHE
- National Outcome Measures from MCH Block Grant
- National Performance Measures from MCH Block Grant
- National Survey of Children with Special Health Care Needs, 2001
- Pregnancy Risk Assessment Monitoring System (PRAMS) data from other states (not available in Kansas)

To encourage data-driven decision making, the following information was given for each indicator, where available and applicable:

- Kansas data
- U.S. data
- Healthy People 2010 goal
- Kansas data source
- National data source
- Whether or not county-level data was available
- Comments

See Appendix B for the indicator tables.

Progress

At the end of Meeting #1, the MCH2010 Panel of Experts had an understanding of Title V, Title V needs assessment requirements, and the MCH2010 Needs Assessment process. Detailed lists of indicator needs had been developed. Although the indicators were prioritized, the lists of data needed by each of the population workgroups were extensive. The list was reviewed and revised by BCYF staff based on data availability and resource limitations. In the two months following the meeting, the MCH epidemiologists

compiled data and prepared presentations of key indicators for each Panel of Experts.

Meeting #2

In Meeting #2, the Panel of Experts reviewed key indicators, selected priorities, and suggested strategies for addressing priorities.

"Total process was well lined out and tools well chosen. Facilitator did an excellent job of listening, drawing out consensus, and moving group forward to conclusions."

- Stakeholder comment after Meeting #2

Agenda

- Plenary Session: Review Meeting #1 Results, Charge to Group for Meeting #2
- MCH Population Workgroup Sessions
    - Presentation of Key Data Indicators
    - Identify Possible Priorities
    - Select Top Priorities
- Plenary Session: Synthesize Work of Groups, Note Cross-Cutting Issues Among Workgroups
- MCH Population Workgroup Session: Suggest Strategies for Each Priority

Tools

The Tools used in Meeting #2 are listed below, and copies are included in Appendix C.

Tool	Task Description
Tool #3: Identify Possible Priorities	Select possible priority needs based on data presented.
Tool #4: Q-Sort	Sort possible needs in priority order.
Tool #5: Additional Data Needed	Suggest strategies by public health function for each priority.

Data

BCYF MCH Epidemiologists prepared data presentations and data handouts with key indicators for each group. The epidemiologist or data expert assigned to the group presented the data, which was used in priority need selection.

See Appendix D for the data presentations. (Appendix D materials are not inclusive of all data resources used at Meeting #2.)

Progress

At the end of Meeting #2, each of the workgroups had selected their top priority needs and suggested strategies to address those priorities. After the meeting, BCYF staff refined the list of priority needs (primarily wording changes to make the priority descriptions more succinct) and the strategies. The revised results were sent to the Panel of Experts and their comments were solicited on a response sheet. (See Appendix C.4 for the response sheet.) Revisions were again made to priorities and strategies after receiving feedback from the Panel of Experts.

Meeting #3

"I gained a better understanding of the demands on KDHE staff and better understanding of vast needs."

- Stakeholder comment after Meeting #3

In Meeting #3, the Panel of Experts conducted a capacity assessment using selected Capacity Assessment for State Title V (CAST-5) resources. CAST-5 is a set of assessment and planning tools designed to assist state MCH programs in examining their capacity.

The main objectives of the MCH2010 capacity assessment were:

- To enhance understanding of "capacity" and how it relates to the Expert Panel's work at Meetings 1 and 2,
- To introduce CAST-5,
- To identify the environment for addressing the priorities and strategies from the August meeting, and
- To identify specific resources that need to be developed and suggest first steps.

A more detailed discussion of the capacity assessment process and results is given in the Capacity Assessment section of this document.

Agenda

- Plenary Session: Overview of CAST-5
- MCH Population Workgroup Sessions
    - SWOT Analysis
    - Capacity Assessment

Tools

The Tools used in Meeting #3 are listed in the following table, and copies are included in Appendix E.

Tool	Task Description
SWOT Analysis	Analyze strengths, weaknesses, opportunities and threats (SWOT) by MCH population group.
Capacity Needs Worksheet	Identify and prioritize MCH capacity needs, identify resources to assist with capacity building, and determine first steps towards improvement.

Data

Draft priority and strategy results from Meeting #2 were provided as reference material. (See Appendix G.) Expert Panelists were also given a list of those strategies from Meeting #2 that could be classified as "capacity-building." (See Appendix H.)

Progress

At the end of Meeting #3, the SWOT analyses and Capacity Needs Worksheets were completed by population group. Results were sent to the Panel of Experts. Ms. Ruderman submitted a final report, which has been incorporated into the Capacity Assessment section of this document.

Next Steps

A draft report of the needs assessment process has been made available to the MCH Panel of Experts and to the general public through posting on the KDHE BCYF website at http://www.kdhe.state.ks.us/bcyf.

A summary of the next steps in the needs assessment process are given in the following table.

Timeline	Next Step
February, 2005 – April, 2005	Receive public comment on needs assessment report on website.
February, 2005 – April, 2005	KDHE BYCF staff choose performance measures to evaluate progress on priority needs over next five years.
May, 2005 – June, 2005	Modify needs assessment based on results of public comment.
July, 2005	Submit needs assessment with MCH Title V Block Grant.
August, 2005	Receive feedback from federal reviewers on needs assessment as part of MCH Title V Block Grant.
September, 2005	Make final revisions to needs assessment.
September, 2005 – 2010	Implement actions and strategies to address priority needs and monitor progress.

Strengths and Weaknesses

"The process of identifying priorities and strategies seemed concrete and practical."

- *Stakeholder comment*

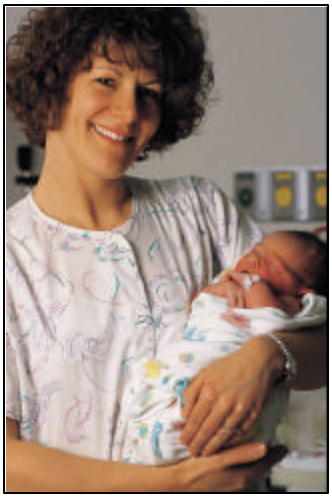
Based on MCH2010 Planning Team debriefing sessions and Panel of Expert evaluation, a summary of the strengths and weaknesses of the process are listed in the table below. (See Appendix F for copies of evaluation forms.) Overall, the process was well-received by both the Panel of Experts and BCYF staff. Most strengths identified were general to the process, while weaknesses cited were suggestions for adjusting a part of the process.

"The capacity needs tool was confusing for agencies or programs outside of KDHE."

- *Stakeholder comment*

Strengths	Weaknesses
• Good involvement of stakeholders • Diverse set of participants • Workgroups organized by three MCH populations allowed each to be well-represented in end products • Use of facilitators to guide process and tools to structure discussion was helpful • Streamlined process allowed for maximum results using the available, limited resources	• Even more family and consumer involvement would have been helpful • Some data requested by stakeholders was not readily available (e.g., cost data, child nutrition/physical activity data.) • Needed more time for discussion on some decisions. • Capacity assessment was confusing to some participants outside of state MCH Title V program.

Assessment of Needs

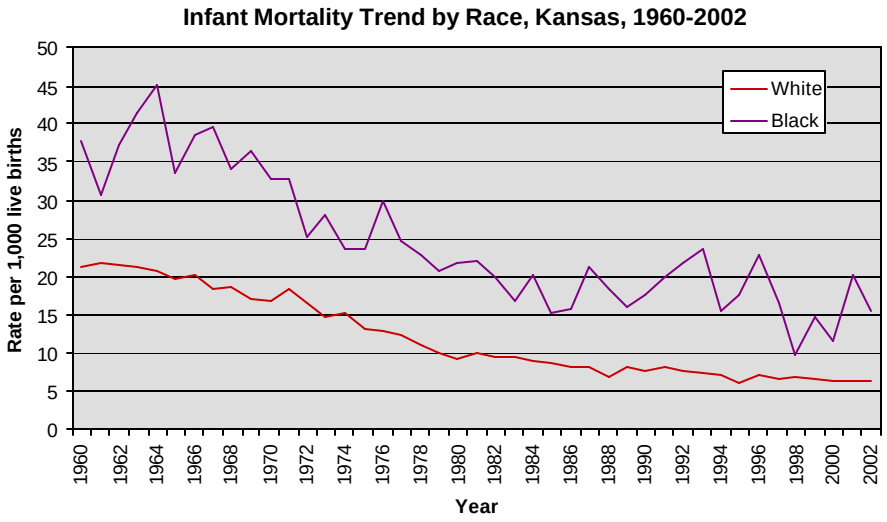


Summaries of needs assessment data presented to the MCH2010 Panel of Experts are included in Appendices B and D. Key indicators from those appendices are highlighted in this section.

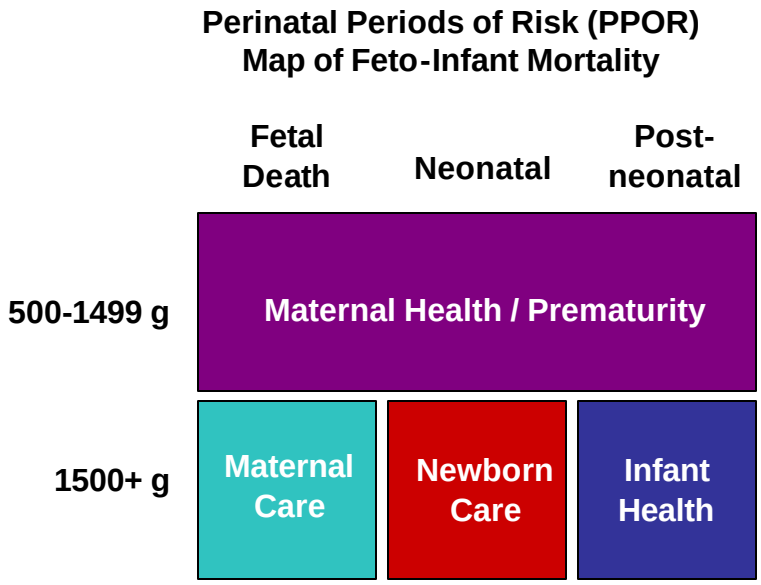
Pregnant Women and Infants

The pregnant women and infants target population was defined by the Panel of Experts as "all women of childbearing age and infants in Kansas." Infants are children under one year of age.

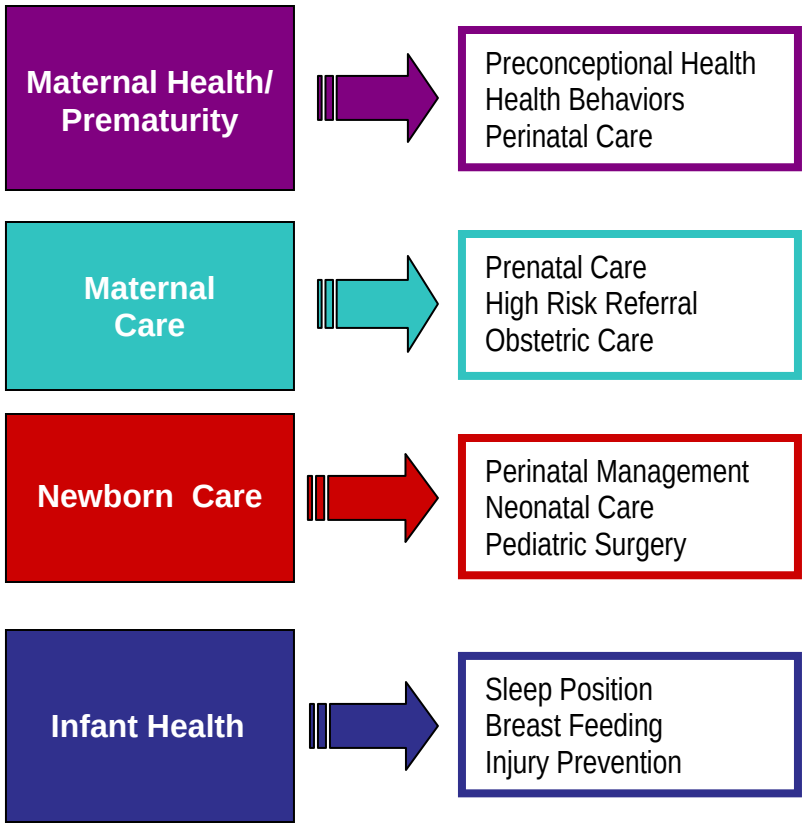
Infant Mortality. Infant mortality rates have declined steadily in Kansas over the past three decades. However, the trend has flattened in the last decade and black infant mortality is still substantially higher than white infant mortality.



Perinatal Periods of Risk. PPOR analysis is a tool to identify excess mortality and to suggest reasons for excess mortality. As such it can provide direction for programs in how best to target resources towards certain populations and which interventions would be most effective.



In the following figure, preventive actions on the right correspond to the preventive direction on the left. For example, preventive actions for maternal care include prenatal care, high-risk referral, and obstetric care.



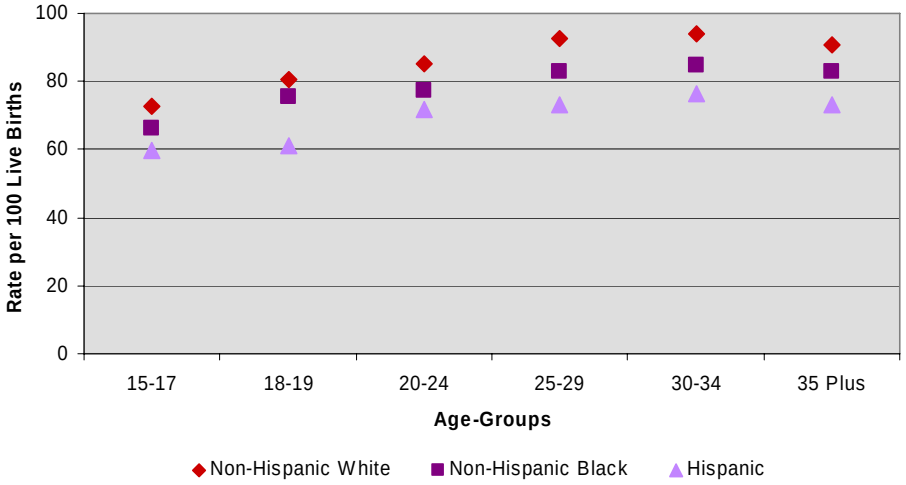
Kansas PPOR data suggest that the community interventions most likely to result in improved health outcomes for infants are those that address maternal health before, during and after pregnancy.

Prenatal Care. In Kansas in 2002, 86.1% of pregnant women started prenatal care in the first trimester of pregnancy. This is slightly higher than the national rate of 82.1%, but below the Healthy People 2010 goal of 90%. Hispanics, African-Americans, and teens had disproportionately lower rates. Geographically, early prenatal care rates are lowest in Southwest Kansas.

Percent Beginning Prenatal Care in the First Trimester
Kansas, 2002

Race	***%***		***Ethnicity***	***%***
White	86.9		Non-Hispanic	88.2
Black	78.9		Hispanic	71.1
Other	82.9			
Total: 86.1%				

Prenatal Care Began in the First Trimester by Age-Group and Ethnicity/Race

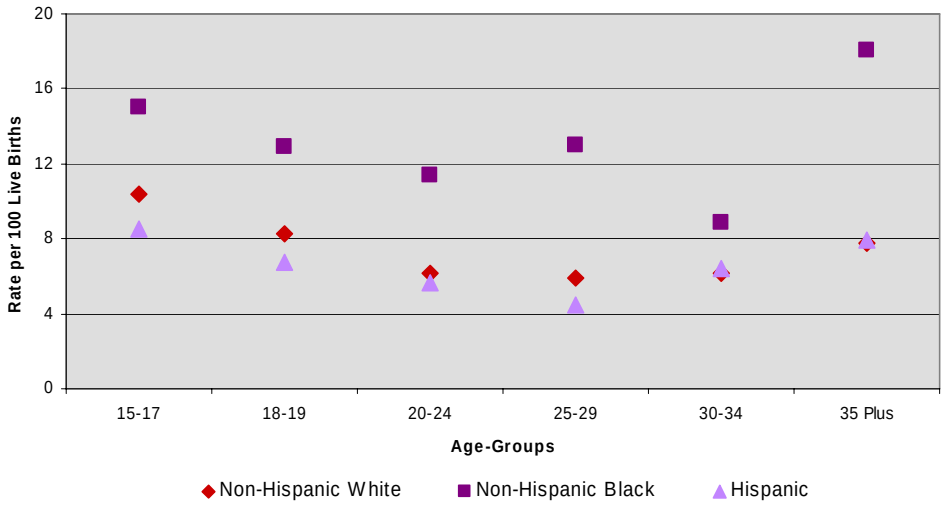


Low Birthweight. Nationally and in Kansas, low birthweight rates increased slightly over the past decade. The 2002 rate for Kansas, 7.0 per 100 live births, was slightly lower than the national average of 7.8 but above the Healthy People 2010 goal of 5.0. African American low birth rates remained disproportionately high.

Low Birthweight Rate (Less than 2500 Grams) Per 100 Live Births
Kansas, 2002

Race	*%*		*Ethnicity*	*%*
White	6.6		Non-Hispanic	7.0
Black	12.4		Hispanic	6.0
Other	5.6			
Total: 7.0				

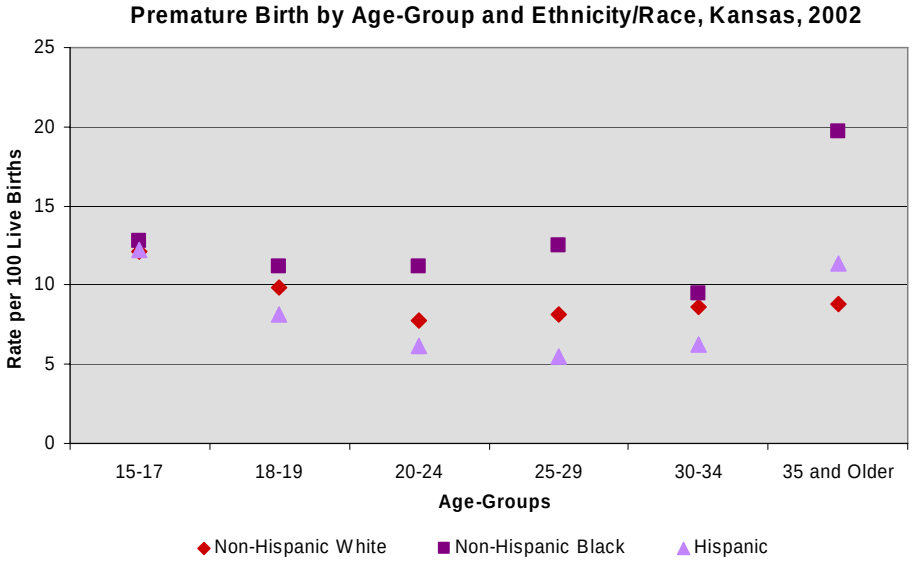
Low Birthweight by Age-Group and Ethnicity/Race, Kansas, 2002



Preterm Births. Nationally and in Kansas, the rates of preterm births (less than 37 weeks gestation) increased slightly over the past decade. Kansas performed better than the national rate, with a rate of 8.6 per 100 births versus 12.1 for the U.S. (2002). The Kansas African-American rate was substantially higher than that for other groups.

Preterm (Less than 37 Weeks) Births
Kansas, 2002

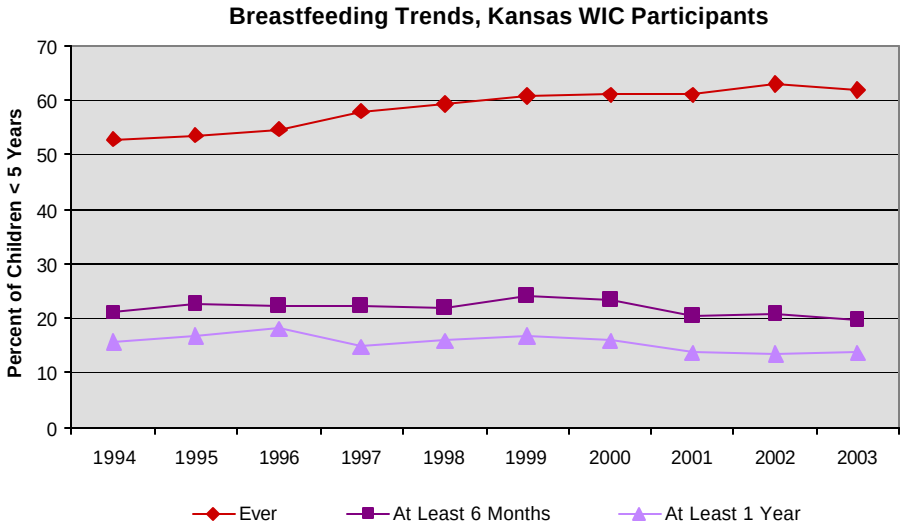
Race	*%*		*Ethnicity*	*%*
White	8.3		Non-Hispanic	8.7
Black	12.3		Hispanic	7.0
Other	7.2			
All Live Births: 8.6				



Breastfeeding. Breastfeeding data for the Kansas population is available through the Ross Labs Mothers Survey and also through the Kansas WIC Program (participants only). For WIC participants, the percent "ever" breastfed increased slightly over the past decade, while the percent breastfeeding at 6 months and at 1 year has been relatively level.

Breastfeeding among WIC Participants x Race/Ethnicity

Race/Ethnicity	*% Ever Breastfed*	*Breastfed At Least 6 Months*	*Breastfed At Least 12 Months*
White, Non-Hispanic	64.0	19.7	13.8
Black, Non-Hispanic	47.0	11.6	8.1
Hispanic	71.3	33.5	20.6
American Indian	66.3	18.1	11.5
Asian	51.0	20.3	19.9



Additional Findings. Selected other pregnant women and infant needs assessment findings are summarized in the following table.

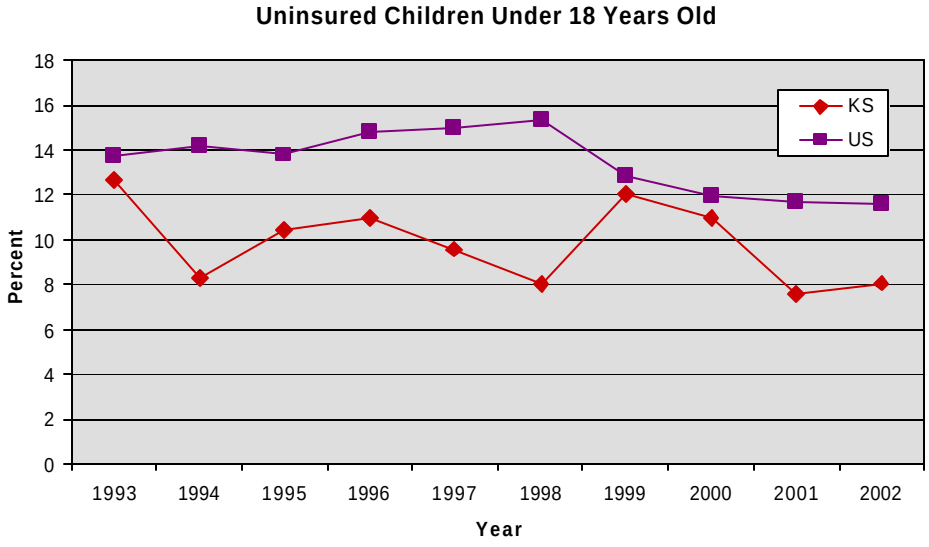
Issue	**Summary Findings**
Smoking During Pregnancy	• In Kansas, 12.5% of mothers reported smoking during pregnancy (certificate of live births, 2002) • Kansas data is slightly higher than the national average of 11.4%. Nationally the trend has been decreasing over the past decade. • The Healthy People 2010 target is ≤ 1% of women smoking during pregnancy.
Alcohol Use During Pregnancy	• Based on PRAMS (Pregnancy Risk Assessment Monitoring System) data from seven states, women aged ≥ 35 years, non-Hispanic women, women with more than a high school education, and women with higher incomes reported the highest prevalence of alcohol use during pregnancy. • The Healthy People 2010 target is ≤ 6% of women using alcohol during pregnancy.

Issue	**Summary Findings**
Postpartum Depression	• Based on PRAMS data from seven states, 7.1% of women reported severe depression after delivery and more than half reported low to moderate depression. • Also based on the PRAMS data, women under age 20 years, African American women, women with fewer than 12 years of education, Medicaid recipients, women delivering low-birth-weight babies, and those experiencing physical abuse during pregnancy were more likely to report severe depression.
Congenital Anomalies	• Nationally and in Kansas, congenital anomalies is the leading cause of infant mortality. • In 2002, there were 63 infant deaths due to congenital anomalies, accounting for 22% of all infant deaths.
Sudden Infant Death Syndrome (SIDS)	• In Kansas in 2001, there were 36 infant deaths classified as SIDS. • The Healthy People 2010 target for putting infants to sleep in the back position, a preventive measure for SIDS, is 70%.
Disparities	• Racial and ethnic disparities were evident in several indicators (low birthweight, infant mortality, prenatal care, preterm births, breastfeeding, etc.)

Children and Adolescents

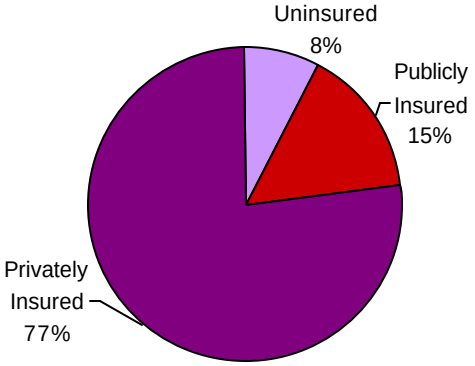
The children and adolescents target population was defined by the Expert Panel as "all children and adolescents in Kansas." The MCH Title V definition of a child: child from first birthday through twenty-first year.

Uninsured Children. In 2002, an estimated 8.1% of Kansas children under 18 were uninsured, compared to 11.6% nationally (U.S. Census Bureau, Current Population Survey).

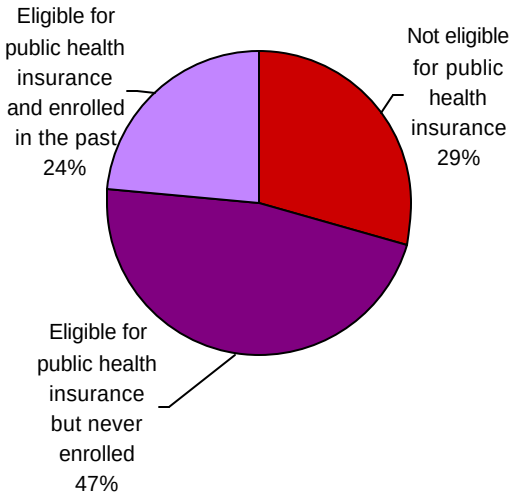


According to a statewide survey conducted in 2001, 15% of children under age 19 were insured through public insurance. Among children who were uninsured, seven-in-ten were eligible for public health insurance but not currently enrolled (Kansas Health Institute, 2003).

Distribution of Kansas Children by Insurance Status, 2001 Children Under 19 Years Old

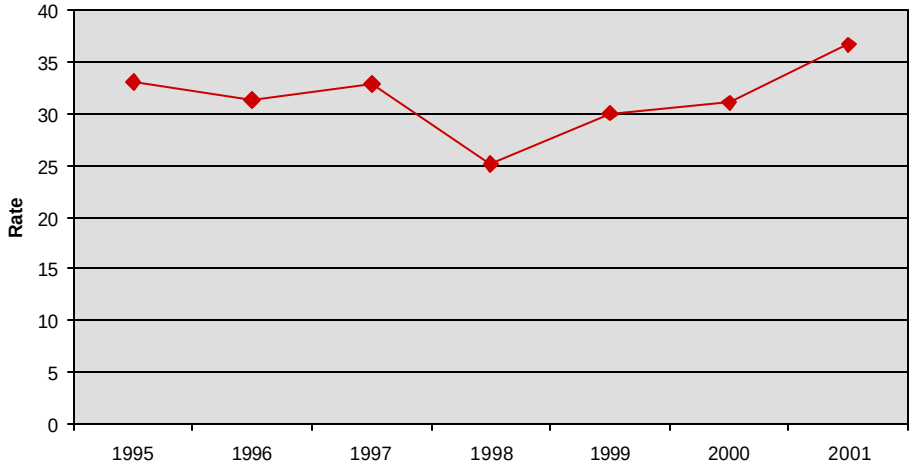


Distribution of Uninsured Children in Kansas by Eligibility and Enrollment in Public Health Insurance, 2001 Children under 19 years old



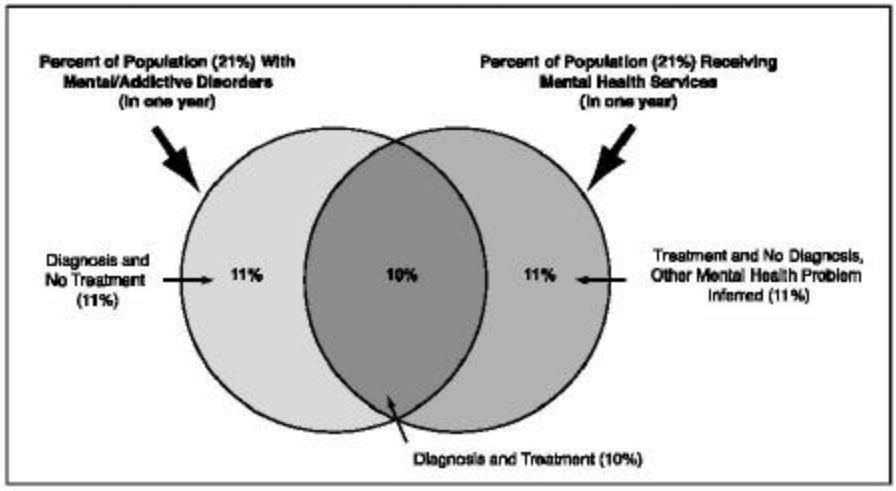
Asthma. Nationally, 5.8% of children have had an asthma attack in the past 12 months, and 12.2% of children have been diagnosed with asthma. In Kansas, the rate of asthma hospitalizations for 1 to 4 year-olds has been increasing over the past four years. The 2001 rate per 10,000 population for white children was 27.5 compared to 71.2 for African American children.

Trend in Asthma Hospitalizations Per 10,000 Population Ages 1 Through 4



Mental Health. Nationally, children's mental health/addictive disorders continues to be an emerging issue. According to the Surgeon General's report on mental health, 21% of children have mental/addictive disorders, and appropriate, evidence-based diagnosis and treatment needs to be improved (1999).

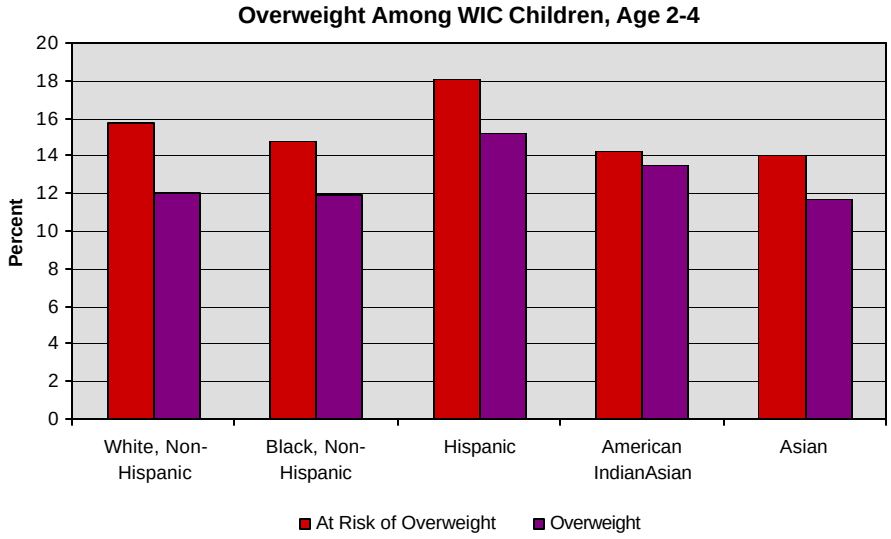
Figure 2-6a. Annual prevalence of mental/addictive disorders and services for children



Children's Behavioral/mental health issues can be identified as early as infancy. Child Care providers and others can assist in early identification.

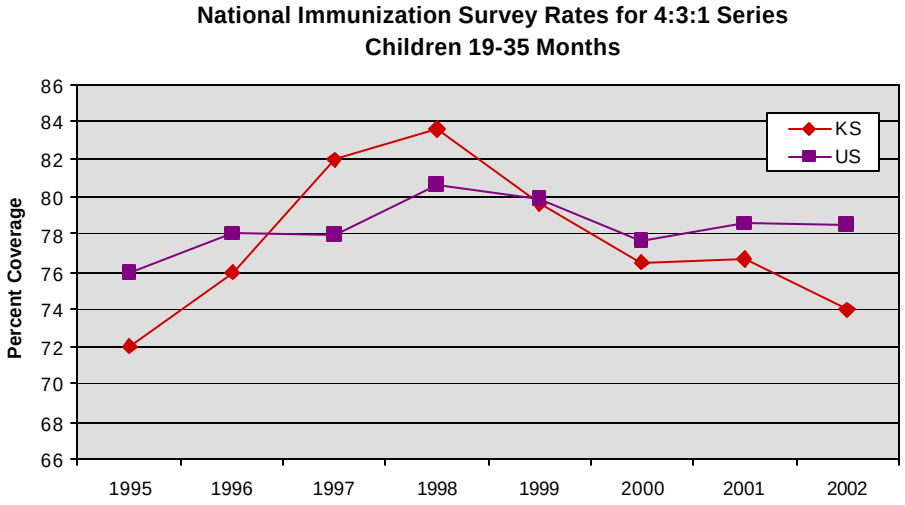
Overweight. An estimated 11% of Kansas adolescents are overweight, and 14% are at risk of becoming overweight (Kansas Youth Tobacco Survey, 2002-2003).

Pediatric Nutrition Surveillance Data (for the low-income WIC population) among children aged 2 to 4 years, showed 16% at risk for becoming overweight and 13% overweight (2003). Hispanics are at greatest risk.

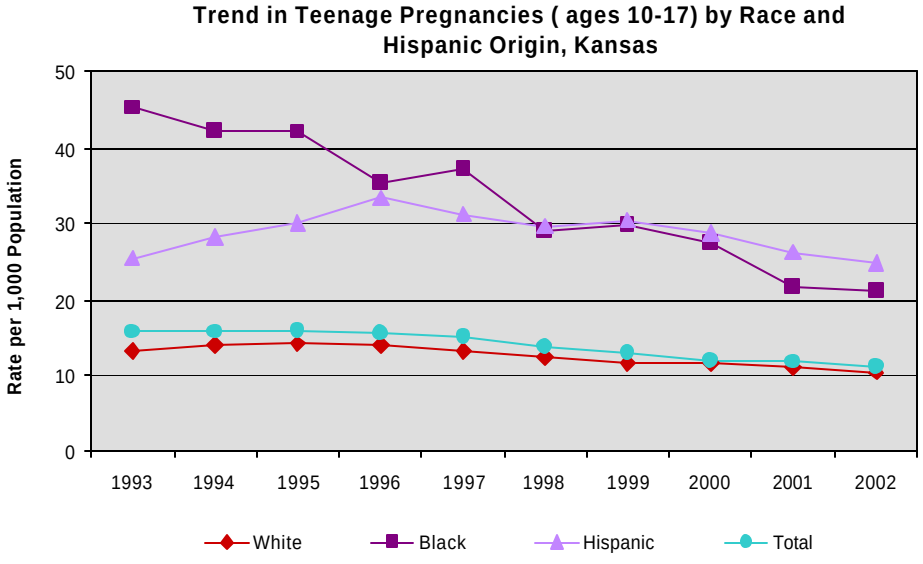


Immunization. Kansas 2002 immunization rates for the 4:3:1 combination (DTP4, Polio3, and MMR1) were slightly below that of the national average (74.0% versus 78.5%). Rates have been declining in Kansas in the past five years (National Immunization Survey).

Recent data analysis by the Kansas Health Institute attributes the lower rates for Kansas to delays in Kansas children receiving the 4th dose of DTP. As an action step, private providers have agreed to step up the administration schedule.



Teen Pregnancy. The teen pregnancy rate for Kansas and for the U.S. has been declining over the past decade. Of note, the African American teen pregnancy rate has decreased over 50% in the past decade.



Additional Findings. Selected other children and adolescent needs assessment findings are summarized in the following table.

Issue	**Summary Findings**
Children in Poverty	• In 1999, 12% of Kansas children were living in poverty. • Southeast Kansas, certain western Kansas counties, Geary county and Wyandotte county had highest rates of children in poverty.
Suicide	• In Kansas, suicide was the second leading cause of death for adolescents aged 15 to 24 years (1998-2002). • The Kansas adolescent suicide death rate is higher than the national average: 15.2 per 100,000 population versus 9.9 nationally (2001).
Illegal Drugs	• Nationally, 22% of students in grades 9 through 12 had used marijuana in the past 30 days, and 4.1% had used a form of cocaine in the past 30 days, and 7.6% had used methamphetamines one or more times during their lifetime (CDC, 2003).
Alcohol Use	• Nationally, 45% of students in grades 9 through 12 drank one or more drinks of alcohol in the past 30 days, and 12% drove after drinking alcohol in the past 30 days (CDC, 2003).
Tobacco Use	• In Kansas, 8% of youth in grades 6 through 8 and 26% of students in grades 9 through 12 currently smoke cigarettes (Kansas Youth Tobacco Survey, 2000).
Oral Health	• The prevalence of untreated decay in third graders in 11 states ranged from 16.2% to 40.2% (Association of State and Territorial Dental Directors, 2003-2004). In Kansas, 25% of third graders have active dental decay (Smiles Across Kansas 2004).
Unintentional Injuries	• Nationally and in Kansas, unintentional injuries are the leading cause of death for children and adolescents over age 1. • The hospital discharge rate for unintentional injury in Kansas has been increasing slightly over the past five years.

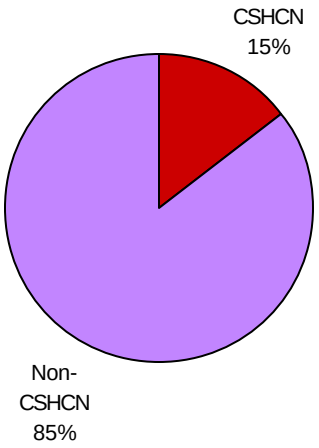
Children with Special Health Care Needs

The Children with Special Health Care Needs (CSHCN) target population was defined by the Expert Panel as "all children with special health care needs in Kansas." Children with special health care needs are defined as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

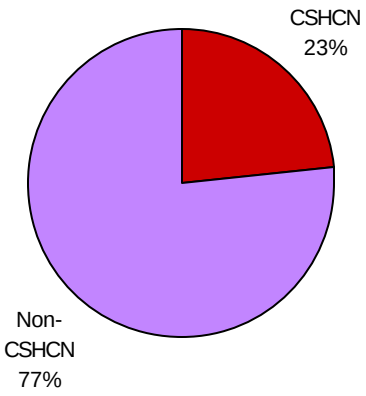
Unless otherwise noted, the source of data in this section was the National CSHCN Survey (2001). Because of the difficulty of including the range of factors that might place children at increased risk for special health needs, the population of children "at risk" was excluded from the survey and results presented here.

Prevalence. An estimated 15% of Kansas children aged 0 to 17 had special needs, which was slightly higher than the percent of children nationally, 13% (2001). Nearly one-quarter of Kansas households with children had a special needs child.

Prevalence of CSHCN in Kansas: Persons (2001)



Prevalence of CSHCN in Kansas: Households (2001)



Considering the demographics of CSHCN, older children in Kansas and nationally were twice as likely as younger children to have a special need (17.7% of 12 to 17 year-olds versus 8.4% of 0 to 5 year-olds). Kansas boys were more likely than girls to have special needs (16.8% versus 12.6%). By race/ethnicity, Hispanic children were least likely to have a special need (9.1% of Hispanics versus 15.4% of White, Non-Hispanics). There was not a significant difference in prevalence between White Non-Hispanic and African American Non-Hispanic children.

CSHCN Indicators. A summary of CSHCN indicators is presented in the table below. In general, Kansas CSHCN faired slightly better than U.S. CSHCN.

Indicator Category	**Indicator**	**Kansas**	**US**
Child Health Status	Percent of CSHCN whose health condition consistently and often greatly affect their daily lives	20%	23%
Child Health Status	Percent of CSHCN with 11 or more days of school absences due to illness	10%	16%
Health Care Coverage	Percent of CSHCN without insurance at some point during the past year	9%	12%
Health Care Coverage	Percent of CSHCN currently uninsured	4%	5%

Indicator Category	Indicator	Kansas	US
Health Care Coverage	Percent of currently insured CSHCN with coverage that is not adequate	31%	34%
Access to Care	Percent of CSHCN with one or more unmet needs for specific health services	19%	18%
Access to Care	Percent of CSHCN without a usual source of care (or who rely on the emergency room)	7%	9%
Access to Care	Percent of CSHCN without a personal doctor or nurse	6%	11%
Family-Centered Care	Percent of CSHCN without family-centered care	30%	33%
Impact on Family	Percent of CSHCN whose families experienced financial problems due to child's health needs	24%	21%
Impact on Family	Percent of CSHCN whose health needs caused family members to cut back or stop working	28%	30%
Transition to Adulthood	Percent of youth with special health care needs who will receive the services necessary to make transitions to all aspects of adult life.	5%*	6%

* Due to small sample size, estimate does not meet the National Center for Health Statistics standard for reliability or precision.

Children Served by Condition. A summary of children served by the KDHE CSHCN program (FY 2004) for selected conditions is given in the below table.

Condition	Children Served by KDHE CSHCN Program
Cerebral Palsy	274
Cleft Lip/Cleft Palate	178
Spina Bifida	76
Cardiology Special Needs	266

Providers by Specialty. The number of KDHE CSHCN providers by specialty is listed in the following table. (Note: All providers are not necessarily currently providing care to children through the KDHE CSHCN program.)

Specialty	Number of KDHE CSHCN Providers
Primary Care	405
Dental	193
Pediatric Cardiologists	26

Priority Needs

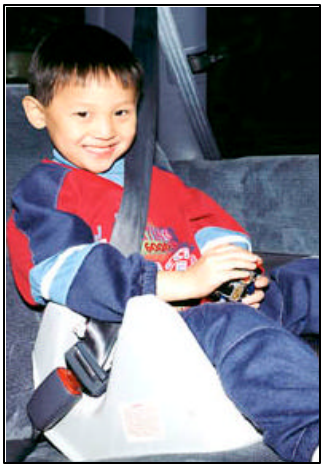
The resulting Kansas MCH2010 priority needs for 2005 through 2010 and brief justifications for their selection are given below.

Priority Need	Why Chosen
Pregnant Women and Infants	
Increase early and comprehensive health care before, during, and after pregnancy	- Among factors within the influence of the MCH system, most effective for improving health outcomes for mothers and infants - Kansas prenatal care rates improving and above national average but below Healthy People 2010 goals and significant racial/ethnic and geographic disparities present
Reduce premature births and low birthweight	- Rates increasing slightly statewide and nationally - Relationship (positive or negative) with other issues of concern: infant mortality, prenatal care, risk behaviors of pregnant women (smoking, drug abuse), access to appropriate medical care for high-risk mothers and newborns
Increase breastfeeding	- Rates well-below Healthy People 2010 goals, especially at 6 and 12 months of age, and for low-income women - Focus on increasing the incidence and duration of breastfeeding (American Academy of Pediatrics [AAP] recommends 6 months exclusive breastfeeding)
Children and Adolescents	
Improve behavioral/mental health	- Behavioral health a priority in previous five years; more progress needed - Potential for improved linkages and relationships between MCH system and behavioral/mental health providers; need for early identification - Relationship with other issues of concern: suicide, drug and alcohol abuse, relationship violence
Reduce overweight	- Increasing problem nationally; limited reliable Kansas data - Strong association with other issues of concern: physical activity, nutrition, chronic diseases, excessive usage of television/computer/video games
Reduce injury and death	- Focus of priority is *preventable* injury and death, especially unintentional and intentional injuries - Unintentional injury -the leading cause of death for all age groups (ages 1-24 years) and the fifth leading cause for infants - Intentional injury - homicide is among the leading 10 causes of death for children/adolescents and suicide is among leading 3 causes of death for adolescents

Priority Need	Why Chosen
Children with Special Health Care Needs (CSHCN)	
Increase care within a medical home	- Unmet access-to-care needs evident from data - Coordinated, family-centered care within a medical home is the key to improved health outcomes
Improve transitional service systems for CSHCN	- Strong need evident from data and reports from providers, consumers, and BCYF staff; only 5% of Kansas CSHCN received services necessary to make transition to all aspects of adult life per national survey
Decrease financial impact on CSHCN and their families	- Substantial need evident from coverage and impact-on-family data indicators and Panel of Experts experience

Three additional focus issues were chosen. Systems are in place to address two of the issues listed below, oral health and teen pregnancy. One issue, asthma, needs a coordinated, statewide public health response. Every effort will be made to maintain or improve efforts in these focus areas given capacity and resources.

Focus Area	Why Chosen
Reduce teen pregnancy and sexually transmitted diseases	- Teen pregnancy rates declining in Kansas, but racial/ethnic and geographic disparities exist and vigilance necessary to continue trend
Improve oral health	- Priority from previous five years; progress made, but important that progress continues - Additional consumer and provider education necessary - Lack of access, particularly among low income, and oral health status troubling
Improve asthma diagnosis and treatment	- Focus on *evidence-based* diagnosis and treatment; evidence-based treatments available to greatly improve quality of life; providers and consumers need to be better educated - Kansas higher than national average, and rates higher in rural areas - No coordinated, statewide effort in Kansas as with other key issues



Potential Strategies

The Expert Panel identified potential actions or strategies to address each priority need by following approaches:

- Provide services directly
- Contract with others to provide services
- Regulate the activity
- Educate public, providers, etc.
- Systems development
- Data system improvement

The resulting potential strategies and action steps are given in Appendix H. Some of the strategies suggested are feasible and will be acted upon; others are not feasible or practical at this time. All were helpful in generating ideas towards approaches to improving the health of Kansas women, infants, and children. These are working documents which will be used and revised by BCYF staff during the next five years.

One cross-cutting strategy, reduce racial and ethnic disparities, was added to address disparities evident in several priority needs.

Capacity Assessment

Background

A critical component of the Title V needs assessment process is the assessment of organizational and system-wide capacity to carry out program and policy activities and meet goals for success.

Capacity Assessment for State Title V (CAST-5) is a set of assessment and planning tools designed to assist state MCH programs in examining their organizational capacity to carry out essential maternal and child health roles and activities. CAST-5 is an initiative of the Association of Maternal and Child Health Programs and the Johns Hopkins University Women's and Children's Health Policy Center, in partnership with the Health Resources and Services Administration's Maternal and Child Health Bureau.

The complete set of CAST-5 tools provide a structure for assessing performance of public MCH program functions in the context of program mission and goals, political, social, and economic context, and population health needs. (The full set of CAST-5 tools and a variety of related resources are available at http://www.amchp.org/cast5.) Specific organizational resources

necessary for optimal performance are identified and form the basis for strategic thinking about capacity-building opportunities. For the purposes of MCH2010, an abridged set of CAST-5 tools was selected for Meeting #3 and modified slightly to fit the Kansas needs assessment process.

Defining Capacity

Capacity can be defined simply as "the ability to do something" (*American Heritage Dictionary*, 1982). In CAST-5, capacity is categorized as 1) structural resources, 2) data/information systems, 3) organizational relationships, and 4) competencies and skills.

- **Structural resources** are financial, human, and material resources; policies and protocols; and other resources held by or accessible to the agency that form the groundwork for the performance of core functions.
- **Data/information systems** are technological resources enabling state of the art information management and data analysis.
- **Organizational relationships** are partnerships, communication channels, and other types of interactions and collaborations with public and private entities.
- **Competencies and skills** refer to the knowledge, skills, and abilities of KDHE staff and their partners in the MCH system.

MCH2010 Capacity Assessment

A schematic of the links between the steps in the MCH2010 capacity assessment process is given below.

Kansas MCH2010 Capacity Assessment Process

Where do we want to be? Where are we now?	→	MCH 2010 Meetings 1 and 2 *Review of MCH indicators* *Top population health priorities* *Potential strategies (starting point)*
What will help or hinder our progress?	→	SWOT Analysis *Identification of strengths, weaknesses, opportunities, and threats related to addressing population health priorities*
What do we need to get there?	→	Capacity Needs Tool *Identification of MCH system and organizational resources needed to implement strategies and address population health priorities*
How do we get it?	→	Recommended "First Steps" and follow up by KDHE *Suggested capacity building activities/first steps to be integrated into KDHE planning activities*

Broadly speaking, there were three steps in the capacity assessment process:

1. Identify strengths, weaknesses, opportunities, and threats to addressing priority health needs;
2. Identify specific system capacities and organizational resources needed to address priority health needs and implement related strategies; and
3. Identify key stakeholders for building the needed capacity and "first steps" for KDHE.

The anticipated end products of these steps were a broad picture of the environment for the state MCH system, conceptualized as cross-cutting strengths, weaknesses, opportunities, and threats for all three workgroups (step 1); a list of system capacity needs ranked by level of importance (step 2); and, for each system capacity need, a list of recommended first steps and stakeholders (step 3). Taken together, these products would form a guiding framework for KDHE efforts to facilitate capacity building in the MCH system and a basis for realistic and strategic planning.

Identification of Strengths, Weaknesses, Opportunities, and Threats

The capacity assessment began with an assessment of factors that could help or hinder the MCH system's progress toward addressing priority health needs in the state. Workgroups used an adapted CAST-5 SWOT Analysis tool to outline strengths, weaknesses, opportunities and threats (SWOT) related to carrying out the strategies and addressing the priorities they identified at the August 2004 meeting. The full Expert Panel then reconvened for workgroup reports. Complete workgroup SWOT results are attached as Appendix I.

A number of cross-cutting strengths, weaknesses, opportunities, and threats were identified and discussed:

Cross-Cutting Strengths

- Many data sets available
- Excellent coalition activity
  - Kansas Action for Children
  - Kansas Association for the Medically Underserved
  - Children's Cabinet
  - Others
- Good MCH staff at KDHE with good working relationships with partners

- "Team players" on a variety of issues
- Increased interagency collaboration
- Governor supportive of public health efforts
- Increased visibility and awareness of health issues in general and specifically with CSHCN
- Increased visibility of issues related to serving diverse populations

Cross-Cutting Weaknesses

- Lack of public and provider awareness
  - Mental health stigma and misconceptions
  - Healthy lifestyles
  - Issues for children also issues for parents (harder to impact)
  - Lack of clarity around medical home terminology
  - Awareness of appropriate training for health professionals
- Data/technological limitations
  - Limited monitoring ability
  - Unable to share data across agencies
  - Lack of trained people to maintain and use the technological resources
  - Not enough analytic capacity
- Lack of bilingual/Spanish-speaking services
- Could be better communication and collegiality in collaborative efforts
- Improvements in system capacity are inconsistent across state
- Not serving rural populations as well as could
- Training needs (e.g. CSHCN)

Cross-Cutting Opportunities

- Education and social marketing opportunities
  - Marketing of medical home concepts
  - Education on contractual requirements in the consortium system
  - Education on the Kansas Nutrition Network
- Have resources in place that could be better utilized and understood
  - Universities and graduate students
  - Parish nurse system
  - Consortium system for mental health services
  - Use of technology for education
- Data collection and analysis opportunities
  - Expand on Kids Count
  - Use school data on height and weight
  - Other opportunities exist as well

- Work with legislators

Cross-Cutting Threats

- Easy to lose sight of "big picture" and goals in light of day-to-day work
- Bureaucratic process takes lots of time
- Geographic and financial disparities
- Fiscal constraints, lack of personnel—impact leadership capacity
- Changes in leadership within agencies
- Political climate (ideology over science, polarized society, hard to discuss issues)
- Public and private fear of the unknown and resistance to change
- Decreased insurance coverage
- Culturally-based desire for independence, less government involvement
- Lack of buy-in at social and political levels (apathy)

Assessment of MCH System and KDHE Resources and Capacity Needs

Following discussion of these environmental factors, the workgroups met again to identify specific resources needed in the MCH system to carry out strategies aimed at addressing priority population health needs. Some of the strategies the workgroups had identified at the second MCH 2010 meeting are in and of themselves capacity-building strategies. Workgroups were encouraged to incorporate those capacity-building strategies into the list of capacity needs they would generate at the capacity assessment meeting. (See Appendix H for the capacity-building strategies.)

Using the CAST-5 Capacity Needs Tool, the workgroups assessed the status of structural resources, data/information systems, organizational relationships, and competencies/skills in the Kansas MCH system. Summarized results are listed below. More detailed summaries by population workgroup are included in Appendix J.

Capacity Strengths

A number of strong resources were identified in the workgroup discussions of the Capacity Needs Tool:

- Communication channels between MCH programs/agencies and consumers/communities (e.g., listservs, newsletters)

- Strong communication and data translation skills, especially at the state level
- Good data/analysis skills
- Good maternal and child health content knowledge
- Experience and expertise in working with and in communities
- Good understanding of the state context
- Access to national data sources
- Active coalitions which influence policymaking
- Linkage with professional groups such as the Kansas Perinatal Association
- Effective public-private agency collaborations and partnership mechanisms
- Relationships with state policymakers
- Mechanisms for accountability and quality assurance are improving
- Good relationships across many KDHE agencies/programs
- Mechanisms for state-local linkages in place (e.g., Kansas Association of Local Health Departments)

Capacity Needs

Participants identified many areas of capacity that could be developed or enhanced in order to better serve children and families in Kansas. Many of these capacities already are in place in the Kansas MCH system but would benefit from further improvement and/or sustained attention. The capacity needs discussions elicited many ideas for capacity-building opportunities and served as the basis for preliminary brainstorming about instrumental stakeholders and "first steps."

Capacity needs rating "high" importance and/or listed by more than one workgroup included:

Structural Resources

- Funding (e.g., for communications coordinator position)
- Authority (e.g., statutory change to allow implementation of Pregnancy Risk Assessment Monitoring System [PRAMS])
- Communication channels between consumers and high-level policymakers
- Improved communication with businesses and private providers
- Improved links to academics
- Partnership mechanisms
- Improved access to up-to-date science, policy, and programmatic information

- Workforce capacity structures and assessment at local level
- State-level board certified lactation consultant
- Formalized accountability and quality assurance mechanisms
- Formalized plans for dissemination of quality standards (e.g., guidelines for perinatal care published in AAP/ACOG's Blue Book, Baby Friendly Hospital Initiative)
- Strengthened accountability for local level outcomes/measures

Data/Information Systems

- Improved data monitoring systems
- Access to timely program and population data
- Supportive environment for data sharing
- Adequate data infrastructure
- Access to insurance data

Organizational Relationships

- Relationships among state agencies (not just within KDHE)
- Relationships with state and national entities enhancing analytical and programmatic capacity
- Relationships with businesses (e.g., for funding opportunities)
- Relationships with local policymakers
- Relationships among KDHE programs/divisions (e.g., for FIMR [Fetal and Infant Mortality Review])
- Relationships with insurers and insurance oversight stakeholders
- Relationships with local providers of health and other services
- Strengthened state-local linkages and understanding around MCH issues

Competencies/Skills

- Communication and data translation skills at the local level
- Management and organizational development skills (e.g., continuing education, cross-training)
- Improved skills with non-English speaking populations

For a full discussion of MCH Capacity by level of the MCH Pyramid, refer to MCH Block Grant Application https://performance.hrsa.gov/mchb/mchreports.

Overall Key Themes and Recommendations

Several overall themes were evident in the SWOT and Capacity Needs results:

- There is a strong base of collaborative relationships to build on. There are many opportunities to capitalize on existing resources and relationships (e.g., expand on available data sources, enhance partnerships with university faculty and students, enhance use/understanding of mental health consortium system, etc.).
- There are inconsistencies in capacity across regions of the state and between the state and local levels (particularly with regard to data analysis and translation).
- The capacity to serve non-English speaking consumers is inadequate.
- Communication channels could be expanded to underutilized sectors (e.g., businesses, private providers). Enhanced communication could assist in laying the groundwork for greater data sharing (e.g., access to insurance data) and for potential funding opportunities.
- The system could benefit from formalized quality assurance and accountability mechanisms at the state and local levels. This process could include examination of workforce capacity and aligning state and local job descriptions and training opportunities with strategic infrastructure needs.
- Challenges to moving forward with capacity-building activities include the difficulty of carving out time from daily work to focus on infrastructure building, getting around bureaucratic barriers to change, and the current fiscal climate.

It is important to acknowledge another significant factor in moving forward with capacity development based on the outcomes of the October 29, 2004 capacity assessment meeting. The capacity assessment was focused broadly on the MCH system as a whole, reflecting the commitment of BCYF leadership to operating within a system development perspective, as opposed to a "silo" mentality. Because many system capacities rest on the resources and capacities of individual system partners, in some cases KDHE has a limited ability to effect capacity development *on a system level*. In these cases, BCYF may need to identify *agency-specific* capacity-building activities that will nonetheless benefit the entire MCH system. In fact, many of the capacity needs identified by the workgroups already are oriented toward the health agency and can serve as the basis for capacity development plans undertaken by

BCYF. BCYF leadership may also identify other capacity needs for which the BCYF has the resources necessary to spearhead broader, system-level capacity building activities.

Recommended Next Steps

In the next few months, it will be important to capitalize on the engagement of stakeholders in the MCH 2010 needs assessment process and to keep participants informed about use of the needs assessment results. It is critical that participants see some tangible actions resulting from their work.

The CAST-5 consultant recommended that the Bureau for Children, Youth and Families implement the following short-term next steps within the next six months.

- Clarify the role of BCYF leadership in advancing the areas of ***system-level*** need identified by capacity assessment participants.
    - Draft specific workplans for initiating this system capacity development work, drawing from the October 29 meeting results (e.g., first steps, instrumental stakeholders).
- Form an ad hoc work group to *examine workgroup results for high priority areas of* ***KDHE organizational capacity development.*** Consider drafting a BCYF capacity development action plan.
    - Identify a clear process for obtaining input on this action plan from other KDHE/BCYF staff and other relevant stakeholders.
    - Identify two to three "winnable" and "doable" goals/objectives that can be accomplished in the next year.
    - Include short and long-term objectives, clearly-defined activities, timeline targets for tasks specified, and clearly defined roles for staff.
    - Identify ways that BCYF will measure success in implementing the action plan.
    - Finalize and disseminate the action plan to KDHE staff and external stakeholders and clearly communicate next steps for its implementation.
    - Integrate the action plan into Title V needs assessment reporting and related planning activities.

"Communicate with stakeholders periodically regarding status of grant and progress against approved grant over next few years."

- Stakeholder suggestion

The consultant recommended that BCYF reconvene the MCH2010 Panel of Experts, or a subgroup of participants, within one year to assess progress toward meeting short-term objectives and activities outlined in the BCYF-specific action plan and system-level capacity development plan(s).

The consultant also recommended that BCYF leadership re-examine the full set of CAST-5 Tools and consider using all or some of the CAST-5 process as the basis for BCYF program performance assessment. The CAST-5 SWOT and Capacity Needs Tools can be used to re-examine the areas of capacity highlighted in the MCH2010 process and assess progress toward internal capacity building.

Looking Ahead

Needs assessment and the identification of potential strategies are only the *first* steps in a cycle for continuous improvement of maternal and child health.

We invite you to join us on this journey of enhancing the health of Kansas women, infants, and children in partnership with families and communities.

Acronyms

AAP: American Academy of Pediatrics

ACOG: American College of Obstetricians and Gynecologists

BCYF: Bureau for Children Youth, and Families

CAST-5: Capacity Assessment for State Title V

CSHCN: Children with Special Health Care Needs

FY: Fiscal Year

KDHE: Kansas Department of Health and Environment

MCH: Maternal and Child Health

MCH2010: Kansas Maternal Child Health Needs Assessment, covering the period 2005 to 2010

PRAMS: Pregnancy Risk Assessment Monitoring System

SWOT: Strengths, Weaknesses, Opportunities, Threats

TVIS: Title V Information System, https://performance.hrsa.gov/mchb/mchreports

WIC: Women, Infants, and Children

Public Comment

Public Comment #1

"I have read the draft and am very pleased with the document. It addresses all the pertinent components of process and identification of the consensus needs per the meetings."

- First Guard

Public Comment #2

"Looks impressive! Will you be sending out the final version at a later date? Thanks."

- Wyandotte County Health Department Representative

Public Comment #3

Kansas Academy Of Family Physicians

7570 W. 21st St. N. Bldg. 1046, Suite C Wichita, KS 67205 316-721-9005
1-800-658-1749 Fax 316-721-9044 kafp@kafponline.org
http://www.kafponline.org

Feb. 18, 2005

Linda Kenney, MPH, Director
Bureau for Children, Youth & Families
Kansas Department of Health & Environment
1000 SW Jackson, Suite 220, Topeka, KS 66612-1274

Dear Ms. Kenney,

Thank you for the opportunity to review the DRAFT MCH 2010 Kansas Maternal and Child Health 5-Year Needs Assessment. You have identified a number of important areas of concern that we share. Our members are the 820+ practicing family physicians in the state. Family physicians are the specialists who take care of more moms and kids than any other health care providers in the state. We applaud you for identifying and isolating many of the health care needs for this important group. We applaud you for selecting the priority needs. We are especially concerned about the priority of unmet access-to-care needs. The concept of the medical home is a key in which our members are heavily involved. We would be happy to work with you to further efforts to see that everyone

In addition to that focus, we note the intent to coordinate among and between various branches of KDHE. In that light, we urge you to further coordinate with KDHE's Tobacco Use and Prevention Program and focus on preventing tobacco use, the number one preventable cause of death in Kansas. We urge you to further coordinate with the KDHE's Immunization Program to see that our immunization rates rise in the state. A coordinated approach to these 2 issues alone will address many of the health care needs our members see everyday in their practice of medicine.

We also note that your notes on Structural Resources regarding data are of interest to us as well. We have concerns about the aging physician workforce and have been working to identify data sources. While it appears to exist and we hope to eventually gain access to it, we are certain that your statement about improving communication with data resources is very important.

Finally, we would volunteer to be involved in the group analyzing the KDHE organizational capacity development.

Thanks again for the opportunity to comment.

Sincerely,

Carolyn Gaughan, CAE
Executive Director

The mission of the Kansas Academy of Family Physicians is to promote access to and excellence in health care for all Kansans through education and advocacy for family physicians and their patients.

Public Comment #4

Kansas SAFE KIDS

1000 SW Jackson Street
Suite 230
Topeka, KS 66612-1274
(785) 296-1223
(785) 296-8645 (FAX)
jstegelm@kdhe.state.ks.us

March 9, 2005

Linda Kenney, Director
Bureau for Children, Youth & Families
Kansas Department of Health & Environment
1000 SW Jackson, Suite 220
Topeka, KS 66612-1274

Dear Ms. Kenney,

Thank you for the opportunity for Kansas SAFE KIDS to review and comment on the draft MCH 5-year needs assessment. We are pleased that you have implemented a comprehensive process for identifying and prioritizing the needs of Kansas children. We are particularly pleased that the assessment is data driven, and that prevention of unintentional injuries in Kansas children has been identified as a priority need for the children and adolescents population group. As you know, unintentional injuries are the leading cause of death for Kansas children. Our Coalition is also very interested in the area of cost information development as identified in your assessment as a need in our state.

We are also supportive of your emphasis on coordination of efforts. Members of our Coalition are interested in working with MCH programs to appropriately integrate proven unintentional injury prevention interventions and to assist as needed with your program planning needs.

Please let me know if we can be of assistance in your efforts to keep our children safe and healthy.

Sincerely,

Elena Nuss

Elena Nuss, Chairperson
Kansas SAFE KIDS Coalition

Public Comment #5

The University of Kansas Medical Center

School of Medicine
Developmental Disabilities Center

(913) 588-5900

March 25, 2005

Linda Kenney, MPH, Director
Bureau for Children, Youth & Families
Kansas Department of Health & Environment
1000 SW Jackson, Suite 220
Topeka, KS
66612-1274

Dear Ms. Kenney,

Thank you for giving us the opportunity to review the DRAFT MCH 2010 Kansas Maternal and Child Health 5-Year Needs Assessment document. We applaud particularly the emphasis on making certain that the children of Kansas have a medical home.

Developmental surveillance and screening is one very important activity that should take place in the medical home. Since our last MCH 2010 planning meeting, the CDC has initiated an awareness campaign to educate parents about childhood development, including early warning signs of autism and other developmental disorders. The CDC notes the necessity of "preparing the health community to deal with the increased questions and requests for information from parents".

The CDC also notes that "developmental screening can be done by various professionals in healthcare, community, or school settings". Given some of the barriers to optimal developmental screening in primary care practice, we would also support KDHE in efforts to expand routine developmental screening in Kansas beyond the physician's office. In Kansas, there are approximately 50,000 infants and toddlers in either center or home-based group child care, and another 22,000 children in child care provided by friends and family. Although the child care setting has not been a traditional target for developmental screening – child care providers have intimate knowledge of the children they care for, and the child care setting might be an ideal setting within which to target developmental screening efforts.

In summary - given increasing evidence that early intervention optimizes developmental outcomes for children with developmental delays and with autism, we would urge KDHE to expand opportunities for children to get state of the art developmental and autism screening in a variety of settings. We will also need to help prepare the health community of Kansas to make decisions for children who fail screening. KDHE should promote evidence-based screening practices for both developmental delay and autism. Many clinicians do not do screening, and even those following KBH guidelines for developmental screening will find that the suggested screening tests include tools that are no longer considered adequate (e.g. the Denver Developmental Screening Test – II), and that they do not include screening tests for autism. Furthermore,

there are now practice guidelines for medical evaluation of developmental delay and autism that need to be promoted in primary care.

We would be happy to work with KDHE to improve physician capacity for developmental screening and to promote physician-early intervention communication. We would also be happy to work with KDHE to support developmental screening in child care settings.

Sincerely,

Kathryn Ellerbeck, M.D.
Neurodevelopmental Pediatrician
Fellowship Director
Developmental Disabilities Center
University of Kansas Medical Center

R. Matthew Reese, Ph.D.
Licensed Psychologist
Training Director
Developmental Disabilities Center
University of Kansas Medical Center

Chet Johnson, M.D., F.A.A.P.
Neurodevelopmental Pediatrician
Professor of Pediatrics and Center Director
Developmental Disabilities Center
University of Kansas Medical Center

Georgina Peacock, M.D., F.A.A.P.
Developmental Behavioral Fellow
Developmental Disabilities Center
University of Kansas Medical Center

Jessica Foster, MD
Developmental Behavioral Fellow
Developmental Disabilities Center
University of Kansas Medical Center

Public Comment #6

March of Dimes
Saving babies, together

Greater Kansas Chapter
4050 Pennsylvania, Suite 141
Kansas City, Missouri 64111
816-561-0175

May 3, 2005

Linda Kenney, MPH, Director
Bureau for Children, Youth and Families
Kansas Department of Health and Environment
1000 SW Jackson, Suite 220
Topeka, KS 66612-1274

Dear Linda:

On behalf of the March of Dimes Greater Kansas Chapter, I thank you for the opportunity to participate as a panelist in the Kansas Maternal and Child Health 5-Year Needs Assessment process. I congratulate you on designing a process that effectively incorporates input from a large group of stakeholders representing diverse interests within maternal and child health. As you begin to design specific strategies to address the identified priorities, I would like to encourage you to include state performance measures in two specific areas:

1. ***Increased access to smoking prevention and cessation programs for pregnant women and women of childbearing age.*** *(Pregnant Women and Infants Subcommittee, Priority #2: Reduce premature births and low birthweight)*

   The March of Dimes is currently in the third year of a national research, awareness, and education campaign focused on premature birth. Originally designed as a five-year campaign, this initiative has recently been extended through 2010.

   Of course, premature birth is a complex problem with numerous contributing factors, many of which remain unknown at this time. However, smoking during pregnancy is a clearly defined risk factor that has a direct impact on pregnancy outcomes, and that can be modified during the course of pregnancy. In a 2001 report on women and smoking, the U.S. Surgeon General concluded that approximately 20% of the incidence of low birthweight in the U.S. can be attributed to smoking. The good news is that women who stop smoking during pregnancy can significantly reduce their risk of delivering a premature and/or a low birthweight baby.

   According to the Perinatal Casualty Study, approximately 12% of Kansas women smoke during pregnancy. The Surgeon General concludes that women who smoke are more likely than non-smokers to give birth to their babies prematurely. Pregnant women who smoke are also at higher risk of having a low birthweight baby - even if the baby is not born too early. Infants of women who smoke during pregnancy are 20-30% more likely to die before birth or within the first month of life. And, the risk of SIDS (Sudden Infant Death Syndrome) triples for babies whose mothers smoke during and after pregnancy.

   The March of Dimes endorses the 5 A's model, developed by the Smokefree Families Coalition, because it has the most consistent data to support its efficacy. Its widespread endorsement by the

American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP) and the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) allows for a uniform approach to smoking cessation among various healthcare professional groups. Continued and expanded collaboration between existing smoking cessation efforts in BCYF programs and the KDHE Office of Health Promotion will strengthen services in public clinics and private practices throughout the state.

2. ***Increased capacity to screen, follow up, and treat infants and children with certain metabolic disorders.***

The March of Dimes supports comprehensive newborn screening for all babies in this country, regardless of their place of birth. Our policy is to support screening for specific conditions when there is a documented benefit to the child and there is a reliable test that enables early detection from newborn blood spots or other means. Based on the results of a study commissioned by the Maternal and Child Health Bureau in the fall of 2004, the March of Dimes expanded its recommended panel of core screening tests to at least 29 tests that meet these criteria. As you know, the Kansas newborn screening program currently offers four of these tests, while 30 other states offer at least 10 tests.

While these conditions are rare, collectively these 29 disorders could affect as many as 1 in 1,500 Kansas babies, according to the National Newborn Screening and Genetics Resource Center. Without early detection, these children can suffer a variety of debilitating symptoms, mental retardation, or even death. The medical care of these children may become very fragmented, as they go from physician to physician searching for a diagnosis of their symptoms.

The expansion of newborn screening and follow-up services in Kansas will require a collaborative effort among several agencies and organizations. We look forward to continuing our joint efforts in this area.

Again, thank you for the opportunity to provide input into the needs assessment process. If I can be of further assistance, please do not hesitate to call on me.

Sincerely,

Norm Hess

Norm Hess, MSA
Director of Program Services and Public Affairs

Public Comment #7

Dear Linda:

….You may recall that I am working on a small project for [the HRSA Maternal and Child Health Bureau] to write up state practices for obtaining public input on MCH block grant applications. I am doing this primarily by reviewing the '05 application sections on public input on line, as well as state health department websites to see what may be up about the MCH block grant. The results of this small study are intended as a resource for states as they plan public input activities for this spring and summer and for future years.

After reviewing all state health agency websites, it appears that at this point in time at least, only a handful are using their websites to actively solicit input into the MCH needs assessment, priorities or plans. Kansas is one of those states, and I wanted to ask you if you would be willing to share a little more information about what these mechanisms are yielding and any thoughts you may have about the value of these activities, especially vis-à-vis effort and cost....

Sincerely,

Catherine A. Hess
Health Policy Consultant
Washington, DC